

Department of Human Resource Management

Use this form when no WCF claim is filed to document injury.

Form 122 found on www.wcf.com should only be used when claim is filed with WCF

EMPLOYEE INJURY REPORT FORM

Employee Injured: _____ SS/EIN#: _____ Title: _____

Home Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: ____/____/____ Assignment Location: _____ Specific Location of Incident: _____

Injury Date: ____/____/____ Time: _____ am/pm Name of Supervisor Notified: _____ Date/Time: _____

Specific Description/Detail of Incident: _____

TREATMENT TYPE: No Treatment Needed ____ Out Patient - Approved WC Doctor ____ Emergency Room ____

Hospitalized ____ Referred to Expert Physician ____ Other ____

Physician Name: _____ Address: _____

Hospital: _____ Phone #: _____

Did Employee Leave Work: Yes ____ No ____ Date: ____/____/____ Time: _____ Date Employee Returned to Work: ____/____/____ Time: _____

Body Part Injured: _____

Type of Injury: _____

Cause of Injury: _____

Did Injury Happen During Performance of Regular Duties: Yes ____ No ____ Unknown ____

Was Injury Caused During Course of Employment: Yes ____ No ____

Did Injury Occur on USDC Premises: Yes ____ No ____

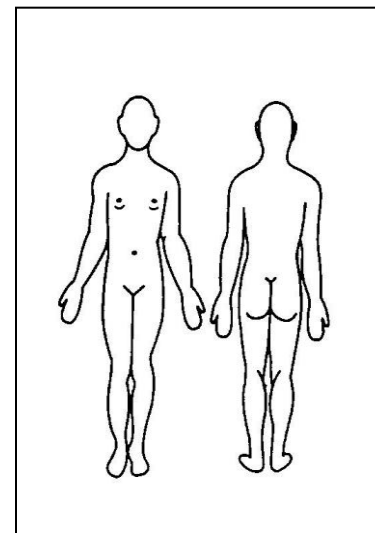
Did Injury Cause Fatality: Yes ____ No ____

Was Injury Caused by Another Employee: Yes ____ No ____

Was Injury Caused by a Client: Yes ____ No ____

Has This Body Part Been Injured Before: Yes ____ No ____

If Yes Give details: _____



Name of Spouse, Minor dependants, and Their Birth Dates:

NAME

RELATIONSHIP

BIRTH DATE

PRESENT ADDRESS

Equipment, materials, chemicals employee was using when accident occurred: _____

Was accident caused by failure of a machine or product: Yes ____ No ____ (If yes explain) _____

Employee Signature: _____ Date: _____

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STAFF INJURY REPORT FORM

WITNESS INFORMATION:

NAME

TITLE

PHONE #

Location

What was happening at the time of the accident and why was it taking place? _____

What were the events leading up to the accident? Describe the sequence in order and when they took place. _____

What exactly caused the injury and how did it happen? What were the mechanics, equipment, or tools involved?

If a physical injury was avoided, what could have happened to cause an injury?

What could have prevented this incident?

After review of all facts, what was the root cause, (hazardous condition, unsafe work practice, or other causal factors (procedure, equipment, people, and environment)) that contributed to the accident / injury?

What do you recommend to prevent this type of accident from occurring again?

Actions taken to ensure recommendations are considered:

_____ Date _____

_____ Date _____

_____ Date _____

ADDITIONAL COMMENTS: _____

Notice Given To: Employee's Supervisor

Date: _____

Director/Manager of Department or Section Dag

Date: _____

Training Provided To: _____

Date: _____

REVIEW DATE: